Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Texas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Youth Empowerment Services (YES)

C. **Type of Request: new**

☐ **New to replace waiver**

Replacing Waiver Number:

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number
(if applicable):

Effective Date: *(mm/dd/yy)*

Waiver Number: TX.0657.R00.00
Draft ID: TX.17.00.00

D. **Type of Waiver** *(select only one):*
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
09/01/09

Approved Effective Date: 09/01/09

1. Request Information (2 of 3)

F. **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☑ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- (●) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- ( ) **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Health and Human Service Commission (HHSC) is the single state agency for Medicaid in Texas and has final authority in the State for Medicaid policies and operations. The Department of State Health Services (DSHS) is the operating agency for the YES waiver.

HHSC was authorized by the Texas Legislature to develop and implement a plan to prevent custody relinquishment of youth with serious emotional disturbances. To this end, HHSC was authorized to seek any necessary waivers or authorizations from the federal government. After review of various options, HHSC and DSHS, in collaboration with stakeholders, decided to request Youth Empowerment Services (YES) 1915(c) Medicaid waiver to improve access to services and allow more flexibility in providing intensive

community-based services and supports for youth with serious emotional disturbances (SED) and their families.

The goals of the waiver include:

•Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies,
•Providing a more complete continuum of community-based services and supports for children and adolescents with SED and their families,

•Ensuring families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process,
•Preventing entry and recidivism into the foster care system and relinquishment of parental custody, and
•Improving the clinical and functional outcomes of children and adolescents.

The objective of the YES waiver is to provide community-based services in lieu of institutionalization to a maximum of three-hundred children at any given time.

The HHSC Medicaid/CHIP Division will provide oversight of the waiver. DSHS will operate the waiver on a day-to-day basis. DSHS will recruit waiver providers, process provider applications, contract with waiver providers, and provide quality and financial oversight of waiver administration and operations, including approval of level of care and plans of care.

DSHS has designated local mental health authorities within each of the geographic service areas of the state. Local mental health authorities are charged with the responsibility of screening people seeking admission to psychiatric facilities in their area to determine the least restrictive treatment environment and effecting continuity of community-based services. DSHS will contract with the local mental health authorities to perform some administrative functions at the local level. Local mental health authorities will: recruit and accept referrals of potential waiver recipients, evaluate waiver applicants and recommend a level of care, provide potential recipients with a choice of waiver or institutional services and with written and verbal information regarding all providers of waiver services, perform utilization management functions and transition planning.

HHSC and DSHS will contract with waiver provider agencies in an open enrollment process. Waiver provider agencies will be required to provide / arrange for all waiver services. Waiver recipients will have a choice of waiver provider agencies and of individual providers within these waiver provider agencies.

Case management for waiver participants will be provided via Medicaid State Plan targeted case management. The local community mental health centers will provide case management functions as stipulated in the Texas Medicaid State Plan. The case manager will develop the waiver recipient's plan of care using the wraparound planning process. The plan of care will identify needed waiver and non-waiver services and supports. All waiver services will be provided in accordance with the waiver recipient's plan of care.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of

waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ○ **No**
- ◉ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☑ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
The waiver will be limited to individuals residing in Bexar County and Travis County. Both counties will begin enrollment simultaneously.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver.

Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Texas Integrated Funding Initiative (TIFI) was the primary statewide children's mental health stakeholder group involved in the original conception of the waiver and has provided input throughout its development. DSHS released a Request For Information that was posted electronically on November 29, 2007, as well as distributed to all mental health and substance abuse contracted providers and a list of advocacy groups interested in behavioral health issues. Input from respondents was used to make additional changes to the waiver proposal. DSHS has also sought input from the Mental Health Public Advisory Committee (MHPAC), the Texas Council of Mental Health Mental Retardation Centers, and the Community Resources Coordination Groups (CRCGs). DSHS will ensure ongoing communication with TIFI and MHPAC throughout the implementation of the waiver. Public Notice of Intent was published in the Texas Register on May 2, 2008. Tribal Notification was mailed to the tribes on May 2, 2008, allowing a comment period. One tribe inquired and responses were sent on May 7, 2008. Comment period expired on June 6, 2008.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Johnson
First Name:	Betsy

Title:	Policy Analyst for Medicaid/CHIP Policy Development
Agency:	Texas Health and Human Services Commission
Address:	PO Box 85200, MC H 600
Address 2:	
City:	Austin
State:	**Texas**
Zip:	78708-5200
Phone:	(512) 491-1199 **Ext:** ☐ **TTY**
Fax:	(512) 491-1953
E-mail:	betsy.johnson@hhsc.state.tx.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Maples
First Name:	Mike
Title:	Director, Program Services Section
Agency:	Department of State Health Services
Address:	Mail Code 2018
Address 2:	909 W. 45th St.
City:	Austin
State:	**Texas**
Zip:	78751
Phone:	(512) 206-5968 **Ext:** ☐ **TTY**
Fax:	(512) 206-5019
E-mail:	mike.maples@dshs.state.tx.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Betsy Johnson
	State Medicaid Director or Designee
Submission Date:	Feb 17, 2009

Last Name:	Traylor
First Name:	Chris
Title:	State Medicaid Director

Agency:	Texas Health and Human Services Commission
Address:	11209 Metric Blvd H-100
Address 2:	
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Phone:	(512) 491-1463
Fax:	(512) 491-1977
E-mail:	chris.traylor@hhsc.state.tx.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

       (Complete item A-2-a).

   - **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:
     Texas Department of State Health Services

     In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or

memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
In 2004, the Texas Legislature reorganized its health and human services system to an organizational umbrella with an oversight agency, the Health and Human Services Commission (HHSC) that also functions as State Medicaid Agency. In accordance with 42 CFR Sec. 431.10 (e), the HHSC is the single state Medicaid agency and retains administrative authority over the waiver program. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the state's health and human services agencies. The financial management and accounting services of each of the agencies receiving Medicaid funds are the responsibility of HHSC.

The designation of HHSC as the single state agency with authority to specifically direct the workings of the Medicaid program in each agency is echoed in TEX GOV'T CODE Sec. 531.021:
(a) The commission is the state agency designated to administer federal medical assistance funds.
(b) The commission shall:
(1) plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The state Medicaid agency has delegated to the Department of State Health Services (DSHS), an agency under the health and human services authority, responsibility for administration of waiver services, ensuring compliance with requirements, ensuring confidentiality, and maintaining records. HHSC directly determines waiver payment amounts or rates. DSHS will report to HHSC no less than annually regarding administrative activities for which DSHS has responsibility.

HHSC and the operating agency are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to home and community-based services waivers. The agreement also outlines the state Medicaid agency's monitoring and oversight functions. HHSC's Long-Term Supports and Services (LTSS) Policy Unit of the State Medicaid Director's office is directly responsible for monitoring and oversight. The operating agreement will be executed prior to the requested waiver effective date of September 1, 2009.

The LTSS Policy Unit is responsible for approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

HHSC and DSHS are working to develop a Quality Improvement Strategy for this new waiver over the next year. HHSC's involvement and oversight in the development of enhanced waiver quality assurance mechanisms under the new CMS guidelines will ensure continued development of HHSC oversight of all areas of waiver operations, as outlined below.
HHSC will monitor to ensure that DSHS:
Disseminates and oversees dissemination of information concerning the waiver to potential enrollees and assists individuals in waiver enrollment by reviewing DSHS consumer education and outreach materials;
Manages waiver enrollment against approved limits and monitors waiver expenditures against approved levels by reviewing DSHS interest list, slot allocation and client count reports. Enrollment limits are approved by HHSC during the initial, renewal, and waiver amendment processes as cost neutrality calculations are adjusted.

Approves level of care evaluations;

Reviews participant plan of care to ensure that waiver requirements are met;

Performs prior authorization of waiver services and conducts utilization management functions.

HHSC also reviews and approves DSHS' entries on CMS Form 372(S) prior to its submission to CMS.

HHSC plans to participate in at least one site visit each year to enhance knowledge of the program operations and DSHS' monitoring procedures.
HHSC will additionally ensure that DSHS:
Conducts utilization management functions which are reported to HHSC under the new quality indicators.

Recruits providers. HHSC approves and adopts policies governing the recruitment and enrollment of providers.

Executes the Medicaid provider agreement. The requirements in the Provider Agreement used by DSHS will meet or exceed Medicaid requirements. DSHS will execute the provider agreement on behalf of HHSC, the Texas Single State Medicaid Agency.
Conducts training and technical assistance concerning waiver requirements. The need for training and technical assistance is identified through results of DSHS' provider monitoring, technical assistance contacts, and the use of newly developed quality indicators. HHSC monitors DSHS' training using the quality indicators and reserves the right to discuss, review or suggest additional training topics for DSHS providers.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   - ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   - ○ **Not applicable**
   - ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:

       Local Mental Health Authorities, public agencies under the control of local elected officials, will perform the following administrative functions under written agreement with HHSC and DSHS:

       * participant waiver enrollment
       * managing waiver enrollment against limits approved by HHSC/DSHS
       * managing waiver expenditures against levels approved by HHSC/DSHS
       * evaluating the participant and recommending the Level of Care to DSHS. DSHS will approve the level of care.
       * review of participant service plans
       * prior authorization of waiver services
       * utilization management

* quality assurance and quality improvement activities

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DSHS is responsible for the oversight of the local mental health authorities.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DSHS will conduct at least annual reviews of the local mental health authorities' compliance with the functions delegated in appendix section A-7. These reviews will examine LMHA policies, procedures and operation of the functions delegated in section A-7. These reviews will also monitor provider compliance with requirements for criminal history and registry checks.

The Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported to HHSC, via these indicators and associated reports.

DSHS staff will monitor utilization data, as well as all claims.

DSHS staff will provide clinical, administrative, and technical assistance to the local mental health authorities. The DSHS staff will identify inefficiencies and barriers to desired outcomes and make recommendations for program and administrative modifications.

DSHS also conducts a quarterly risk assessment of the local mental health authorities which generates a risk report. If the local mental health authority is at risk then a desk and/or on-site review is conducted. If the review detects areas of risk, the local mental health authority prepares a corrective action plan in conjunction with DSHS. If the local mental health authority does not correct the problem, then DSHS will apply corrective action, which may include sanctions.

DSHS also conducts semiannual data verification via desk review. This process can also generate a corrective action plan if deficiencies are discovered.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment			

	☐	☑	☑
Waiver enrollment managed against approved limits	☐	☑	☑
Waiver expenditures managed against approved levels	☐	☑	☑
Level of care evaluation	☐	☑	☑
Review of Participant service plans	☐	☑	☑
Prior authorization of waiver services	☐	☑	☑
Utilization management	☐	☑	☑
Qualified provider enrollment	☐	☑	☐
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.1. DSHS conducts annual reviews to determine local mental health authority compliance with their performance contracts.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.2. DSHS conducts data verfication reviews on local mental health authorities.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
A.3. The State has a current operating agreement between HHSC, the single state Medicaid umbrella agency, and DADS, an operating agency of HHSC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agreement

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.4. The operating agreement outlines the roles and responsibilities of HHSC and DADS for operating the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agreement

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.5. The State annually reviews the operating agreement.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minutes of operating agreement review meeting.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other** Specify:

Performance Measure:
A.6. HHSC and DSHS meet to review quality performance and develop remediations and program improvements.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency, HHSC, retains administrative authority over the waiver program. HHSC is actively involved in development of and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of quality assurance activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Training and technical assistance are provided by the DSHS Quality Management Unit to local mental health authorities initially and on an ongoing basis. A quarterly risk assessment of local mental health authorities is also conducted. If problems are identified, DSHS will conduct a review and report to the local mental health authorities. A plan of improvement will be developed by the local mental health authorities. If the plan is not followed and improvements are not implemented, the problem is referred to the DSHS Mental Health Substance Abuse contract unit for remedial action and possible sanctions.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
◉ **Mental Illness**					
	☐	**Mental Illness**			
	☑	**Serious Emotional Disturbance**	3	18	

b. Additional Criteria. The State further specifies its target group(s) as follows:

N/A

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The local mental health authority, under its agreement with HHSC and DSHS will be required to ensure that youth who turn 19 while in services are transitioned to adult services at least six months before their 19th birthday. A transition plan must be developed in consultation with the youth, the Legally Authorized Representative (LAR) and the future providers with adequate time to allow both current and future providers to transition the youth into adult services without a disruption in services. The transition plan must include:
1. a summary of the mental health community services and treatment the adolescent received as a youth,
2. the youths' current status (e.g., diagnosis, medications, level of functioning) and unmet needs,
3. information from the youth and the LAR regarding the youth's strengths, preferences for mental health community services, and responsiveness to past interventions, and
4. a plan of care that indicates the mental health and other community services the youth will receive as an adult and ensures the youth's continuity of services without disruption.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The waiver is designed for youth who need essential services and supports to continue to reside in their home. The waiver is not intended to serve youth requiring intensive out-of-home residential treatment for an extended period of time.

Prior to initiating enrollment into the waiver, the local mental health authority will conduct a brief interview and administer the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG) to determine the youth's current level of need. If the youth and their family indicate that their expectation of services includes a minimal use of residential services, and the assessment indicates that the child or adolescent qualifies for the waiver, waiver enrollment will be pursued. The waiver recipient and family will be informed that if the waiver recipient is determined to be a danger to self or others, and adequate safety cannot be assured in the community, the waiver recipient will be placed in a more restrictive setting.

Upon application for the YES program, applicants and/or LARs will be notified by the Local Mental Health Authority of their right to the Medicaid Fair Hearing process, if they are not given a choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are denied, suspended, reduced or terminated.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☑ **Other safeguard(s)**

Specify:

Waiver participants must have a plan of care at a cost within the cost ceiling. For waiver participants with needs that exceed the cost limit the State has a process to ensure their needs are met. The process includes examining third party resources or possible transition to another waiver or institutional services.

The individual will be informed of and given the opportunity to request a fair hearing, if the State proposes to terminate the individual's waiver eligibility.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of

participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	300
Year 2	600
Year 3	600

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	300
Year 2	300
Year 3	300

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ○ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ◉ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ○ **Waiver capacity is allocated/managed on a statewide basis.**
- ◉ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often

the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

The waiver capacity will allocated by service area (county). Allocation of waiver capacity is determined by DSHS using information on population, service demand / need and community infrastructure. DSHS will reevaluate the allocation at least annually or more often as needed. Unused capacity will be reallocated to service areas with greater demand / need for services. Each site will be allocated 150 slots initially. On an annual basis, DSHS will review each site's use of waiver slots and will reallocate unused slots in accordance with need.

The state assures that these practices do not violate the requirement that individuals have comparable access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The local mental health authorities must maintain an up to date interest list of applicants living in the local service area who are seeking services through the waiver. Vacancies are offered to individuals on a first come, first served basis according to the chronological date of the individuals' registration on the waiver interest list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 09/01/09

a. The waiver is being (select one):

- (•) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 0

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 300

Month	Base Number of Participants	Change	Participant Limit
Sep	0	60	60
Oct	60	60	120
Nov	120	60	180
Dec	180	60	240
Jan	240	60	300
Feb	300	0	300
Mar	300	0	300
Apr	300	0	300
May	300	0	300
Jun	300	0	300
Jul	300	0	300
Aug	300	0	300

Waiver Year 2
Unduplicated Number of Participants: 600

Month	Base Number of Participants	Change	Participant Limit
Sep	300	0	300
Oct	300	0	300
Nov	300	0	300
Dec	300	0	300
Jan	300	0	300
Feb	300	0	300
Mar	300	0	300
Apr	300	0	300
May	300	0	300
Jun	300	0	300
Jul	300	0	300
Aug	300	0	300

Waiver Year 3
Unduplicated Number of Participants: 600

Month	Base Number of Participants	Change	Participant Limit

Sep	300	0	300
Oct	300	0	300
Nov	300	0	300
Dec	300	0	300
Jan	300	0	300
Feb	300	0	300
Mar	300	0	300
Apr	300	0	300
May	300	0	300
Jun	300	0	300
Jul	300	0	300
Aug	300	0	300

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three
☑	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	**Sep**	
Phase-in/Phase-out begins	**Sep**	**1**
Phase-in/Phase-out ends	**Jan**	**1**

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ◉ **§1634 State**
   - ○ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional State supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All state plan groups except for: 1634(b) Early Aged Widowe(r); 1634(d) Disabled Widowe(r); 1634(c) Disabled Adult Children; and the following Foster Care Groups: 1902(a)(10)(A)(i)(I) and 1902(a)(10)(A)(ii)(XVII)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- ◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ○ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

ii. Allowance for the spouse only (*select one*):

- ( ) **Not Applicable (see instructions)**
- (●) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**

- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

  [ ]

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

  [ ]
- ○ **Other**

  Specify:

  [ ]

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

  Specify:

  [ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Not applicable.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

- **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Master's level clinicians perform the initial evaluation and make the recommendation regarding level of care. The educational / professional qualifications are: licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed psychologist. An medical director is required to verify / concur with any recommendation to deny level of care.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Medicaid eligible youth will satisfy the level of care criteria for waiver services if they meet criteria A and B.

A. Eligible youth must have serious Functional Impairment or Acute Severe Psychiatric Symptomatology as identified on the Child and Adolescent – Texas Recommended Assessment Guidelines (CA-TRAG). The CA-TRAG is a set of standardized measures used in Texas to determine level of service for community-based children's mental health care.

The CA-TRAG utilizes a five point scale (0 = not at all, 5 = all the time) on 10 domains. The 10 domains are:
1) Ohio Youth Problem Severity Scale (score of 30 or greater required)
2) Ohio Youth Functioning Scale
3) Risk of Self-Harm
4) Severe Disruptive or Aggressive Behavior
5) Family Resources
6) History of Psychiatric Treatment
7) Co-Occurring Substance Use
8) Juvenile Justice Involvement
9) School Behavior
10) Psychoactive Medication Treatment

For waiver clinical eligibility the youth must exhibit one or more of the following:
•Score of 4 or 5 on the Risk of Self-Harm dimension,
•Score of 4 or 5 on the Severe Disruptive or Aggression Behavior dimension,
•Score of 4 or 5 on the Family Resources dimension,
•Score of 4 or 5 on the School Behavior dimension, or
•Current diagnosis of Schizophrenia, Major Depressive Disorder with psychosis, Bipolar I with the most recent episode Manic or Mixed,

AND

B. There is a reasonable expectation that, without waiver services, the child would qualify for inpatient care under the Texas Medicaid inpatient psychiatric admission guidelines. These guidelines are:

1. The Medicaid eligible youth must have a valid Axis I, DSM-IV-TR diagnosis as the principle admitting diagnosis, and outpatient therapy or partial hospitalization must have been attempted and failed, or a psychiatrist must have documented reasons why an inpatient level of care is required; and

2. The Medicaid eligible youth must meet at least one of the following criteria:
a) The Medicaid eligible youth is presently a danger to self, demonstrated by at least one of the following:
* Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
* Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting / burning self);
* Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care of self; or
* Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the youth. A medical diagnosis of Axis III which must be treatable in a psychiatric setting.
b) The Medicaid eligible youth is a danger to others. This behavior should be attributable to the youth's specific Axis I, DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
* Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the

plan with the likelihood of acting on the threat;
* Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or
* Active hallucinations or delusions directing or likely to lead to serious harm of others.
c) The Medicaid eligible youth exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of someone with chronic psychosis rendering the child or adolescent unmanageable and unable to cooperate in treatment, and the youth is in need of assessment and treatment in a safe and therapeutic setting.
d) The Medicaid eligible youth has a severe eating or substance abuse disorder, which requires 24-hours-a-day medical observation, supervision, and intervention.
e) The proposed treatment / therapy requires 24-hours-a-day medical observation, supervision, and intervention.
f) The Medicaid eligible youth exhibits severe disorientation to person, place, or time.
g) The Medicaid eligible youth's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.
h) Medicaid eligible youth requires medication therapy, or complex, diagnostic evaluation where the youth's level of functioning precludes cooperation with the treatment regimen.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Texas Medicaid Inpatient Psychiatric Admission Instrument is used to determine level of care for the Waiver. This is the same instrument used to determine clinical eligibility for inpatient psychiatric stays under Texas' State Medicaid Plan and the results are fully comparable. In addition, the CA-TRAG is used to determine level of need for waiver services. The CA-TRAG is a standardized instrument used throughout Texas to assess clinical need for community-based levels of service within Texas' evidenced-based system for Children's mental health.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Evaluation: The local mental health authority's licensed master's level clinician (CMSW, LPC, LMFT or psychologist) conducts the initial clinical interview and completes standard instruments to recommend level of care. A medical doctor is required to verify / concur with any recommendation to deny level of care. DSHS is responsible for approving the level of care.

Re-evaluation: The community mental health center's case manager completes the standard instruments. The local mental health authority's master's level clinician reviews and confirms the recommendation and makes a recommendation regarding level of care. A medical doctor is required to verify / concur with any recommendation to deny level of care. DSHS is responsible for approving the level of care.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure

timely reevaluations of level of care *(specify):*

DSHS provides training and technical assistance to local mental health authorities to educate them on performance of required functions such as evaluation and reevaluation of level of care. The DSHS Quality Management Unit conducts data verifcation reviews on semi-annual basis. A representative sample of level of care evaluations / reevaluations is included in data verfication reviews. Timeliness of completion is one factor examined. In addition, DSHS reviews all waiver claims to ensure that level of care is current prior to authorizing payment.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and reevaluations of level of care are maintained in the following locations: DSHS, local mental health authority, community mental health center, and the waiver provider agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.1. Percent of initial LOC evaluations reviewed by the state.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = ☐
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.2. Percent of level of care re-evaluations reviewed by the state.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.3. Percent of waiver recipient cases in which the CA-TRAG and Psychiatric Inpatient Criteria Assessment Forms are used correctly to determine clinical eligiblity/LOC.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval = [ ]
☐ Other Specify: [ ]	☑ Annually	☐ Stratified Describe Group: [ ]
	☐ Continuously and Ongoing	☐ Other Specify: [ ]
	☐ Other Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: [ ]	☐ Annually
	☐ Continuously and Ongoing
	☑ Other Specify: semi-annually

Performance Measure:
B.4. Percent of LOC denials reversed on appeal.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSHS Data Verification Process

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency, HHSC retains administrative authority over the waiver program. HHSC is actively involved in development of and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of quality assurance activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DSHS Quality Management Unit provides training and technical assistance to the local mental health authorities initially and on an ongoing basis. A quarterly risk assessment is also conducted by DSHS. If problems are identified, DSHS will conduct a review and report to the local mental health authority. A plan of improvement will be developed by the local mental health authority in conjunction with DSHS. If the plan is not followed and improvements are not implemented, the DSHS Quality Management Unit refers the problem to the DSHS Mental Health Substance Abuse Contract Management Unit for remedial action and possible sanctions.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The local mental health authority informs the youth and their LAR of the services available under the waiver. Prior to enrollment,

the LMHA informs them of the right to seek admission to a psychiatric facility, the choice of provider agencies available under the waiver and the right to change provider agencies, if desired. The youth's and LAR's decision is then documented on the Freedom of Choice Form and signed by the youth and LAR. The form will also include a statement informing the youth and LAR that if the situation deteriorates, hospitalization may still occur to ensure the safety of the youth or others.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The local mental health authority retains the Freedom of Choice Form in the youth's case record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Under its contract with HHSC / DSHS, the local mental health authority is required to provide to waiver recipients, including those with a disability (e.g., deafness, hard of hearing, and blindness), information about the waiver in a format and language that is easily understandable and based on the demographics of the population.

Documents that are provided to waiver recipients throughout the enrollment process and service provision will be available in both English and Spanish. If the waiver recipient's primary language is something other than English or Spanish, the local mental health authority, case manager, and waiver service provider agency are required to enlist the assistance of an interpreter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Respite**
Other Service	**Adaptive Aids and Supports**
Other Service	**Community Living Supports (CLS)**
Other Service	**Family Supports**
Other Service	**Minor Home Modifications**
Other Service	**Non-Medical Transportation**
Other Service	**Paraprofessional Services**
Other Service	**Professional Services**
Other Service	**Specialized Psychiatric Observation**
Other Service	**Supportive Family-based Alternatives**
Other Service	**Transitional Services**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Service Definition *(Scope):*
Respite is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in:
* Individual's home or place of residence;
* Private residence of a respite care provider, if that provider is a relative of the participant;
* Foster home licensed by the Texas Department of Family and Protective Services (DFPS);
* Residential treatment facilities licensed by DFPS;
* Day or overnight camps accredited by the American Camping Association;
* Day or overnight camps licensed by DSHS;
* Child care centers licensed by DFPS; and
* Child care homes registered with DFPS.

All settings must be located within the State of Texas.

The contracted waiver provider agency must approve and provide ongoing oversight of respite settings to ensure the safety of the setting. Respite services may be provided by a relative of the waiver recipient other than the parents. Out-of-home respite providers are required to have a functional landline phone on the premises.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment may not be made for respite provided at the same time as other services that include care and supervision. Up to 720 consecutive or cumulative hours (30 days) of respite may be provided per individual service plan year. Temporary exceptions to the respite limit may be considered on a case by case basis. Such exceptions require the written approval of the Director of the DSHS waiver section. Exceptional circumstances may include, but are not limited to:
• parent dies or is hospitalized while the waiver participant is receiving respite care, or
• a catastrophic event, such as a hurricane, flood or other disaster, occurs while the waiver participant is receiving respite, temporarily disrupting the family's ability to provide shelter and care for the waiver participant.
Temporary exceptions will be granted for a defined time period. Costs for all waiver services, including any extended respite, cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Agencies holding a Medicaid YES waiver provider agreement
Provider Qualifications
License *(specify):*
• Foster home licensed by the Department of Family and Protective Services (DFPS) – 40 Tex. Admin. Code Ch. 749
• Residential treatment centers licensed by DFPS – 40 Tex. Admin. Code Ch. 748

• Camps licensed by DSHS – 25 Tex. Admin. Code §§ 265.11 – 265.24
• Child-care centers licensed by DFPS – 40 Tex. Admin. Code Ch. 746
• Child care homes registered or licensed by DFPS – 40 Tex. Admin. Code Ch. 747

Certificate *(specify):*
Not applicable

Other Standard *(specify):*
Respite care personnel must be at least 18 years of age, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2. If respite services are provided at a non-licensed setting, the waiver provider must ensure the safety and appropriateness of the setting. Respite care providers must complete training as required by DSHS.

The out-of-home respite provider must have a functional landline phone on the premises.

Verification of Provider Qualifications

Entity Responsible for Verification:
YES Waiver Provider Agency

DSHS

Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adaptive Aids and Supports

Service Definition *(Scope):*
Devices and supports recommended by a professional services waiver provider to effect a service under the approved individual plan of care. Adaptive Aids and Supports address the waiver participant's needs that arise as a result of their severe emotional disturbance. These devices and supports contribute to the community functioning of waiver participants and thereby assist the participants to avoid institutionalization. Adaptive aids and supports include:

- Therapeutic Peer Support– Provides fees to facilitate the waiver participant's involvement in age-appropriate peer support activities recommended by a Professional Services waiver provider as part of a treatment plan. Includes participation in specialized groups to improve socialization or deal with issues resulting from severe emotional disturbance and/or concommitant physical health issues, such as obesity. For example, membership fees for peer support weight reduction groups recommended by a licensed nutritionist.

- Therapeutic equipment - items necessary to execute and /or maintain a therapeutic plan. May include equipment and supplies related to a professional services treatment plan. Examples could include devices or equipment needed for the child to achieve physical or occupational therapy goals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Minor Home Modifications, Adaptive Aids and Supports, Paraprofessional Services, Professional Services and Non-Medical Transportation have a collective limit of $5,000 annually. Room and board, normal household expenses and items not related to amelioration of the child's disability are not included.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Aids and Supports

Provider Category:

Agency

Provider Type:

Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adaptive Aids and Supports may be provided by recreational equipment suppliers or specialized groups specified in the individual's plan of care and approved by the LMHA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually.

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Supports (CLS)

Service Definition *(Scope):*
CLS are provided to the waiver recipient and family to facilitate the waiver recipient's achievement of his / her goals of community inclusion and remaining in their home. The supports may be provided in the waiver recipient's residence or in community settings (including but not limited to libraries, city pools, camps, etc.) CLS provide assistance to the family caregiver in the disability-related care of the waiver recipient, while facilitating the waiver recipient's independence and integration in to the community. The training in skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included, if these skills are affected by the waiver recipient's disability. CLS may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the waiver recipient to attain or maintain his / her maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. Training may be provided to both the caregiver and the waiver recipient, dependent upon the youth's age, on the nature of the emotional disorder, the role of medications, and self-administration of medications. Training can also be provided to the waiver recipient's primary caregivers to assist the caregivers in coping with and managing the youth's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living Supports (CLS)

Provider Category:
Agency

Provider Type:
Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*
Not applicable

Certificate *(specify):*
Not applicable

Other Standard *(specify):*
Services will be provided by a Qualified Mental Health Professional - Community Services (QMHP-CS), and is defined as an individual who is credentialed to provide QMHP-CS services, who
(a) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
(b) is a registered nurse.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS

Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family Supports

Service Definition *(Scope):*
Family Supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural / non-traditional and community support systems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Supports

Provider Category:
Agency

Provider Type:
Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*
Not applicable

Certificate *(specify):*
Not applicable
Other Standard *(specify):*
The waiver provider agency will credential individual family support providers. Individual providers must meet credentialing requirements, including passing a criminal background check and reference checks. Family Supports providers are individuals skilled and experienced in parenting children / adolescents with behavioral health challenges like those of the population of waiver recipients, including a serious emotional disturbance. A family suport provider must have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; at least one cumulative year of receiving mental health community services for a disorder that is treated in the target population for Texas; and be under the direct clinical supervision of an master's level therapist.

Individuals providing Family Supports must complete a training process through the waiver provider agency on program philosophy, policies and procedures, including reporting of critical incidents and abuse, neglect and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Minor Home Modifications

Service Definition *(Scope):*
Services related to addressing the waiver participant's needs that arise as a result of their severe emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the participants to avoid institutionalization. These services include Home Accessibility / Safety Adaptations - Physical adaptations to the participant's residence, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant. May include alarm systems, alert systems, and other safety devices.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Minor Home Modifications, Adaptive Aids and Supports, Paraprofessional Services, Professional Services and Non-Medical Transportation have a collective limit of $5,000 annually. Room and board, normal household expenses and items not related to amelioration of the child's disability are not included.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:
Agency
Provider Type:
Agencies holding a Medicaid YES waiver provider agreement
Provider Qualifications

License *(specify):*
Minor Home Modifications may be provided by alarm system providers licensed by DSHS under TAC Title 25 Chapter 140 Subchapter B for Personal Emergency Response Systems and/or Texas Department of Public Safety Title 37 Part 1 Chapter 35.

Certificate *(specify):*
NA

Other Standard *(specify):*
Minor Home Modifications must be age appropriate and related to specific therapeutic goals. The provider agency will be required to maintain written documentation of reasonable cost for services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS

Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Non-Medical Transportation

Service Definition *(Scope):*
Non-Medical transportation enables waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR

§431.53 and transportation services under the State plan and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Waiver transportation services may not be substituted for medical transportation services defined under the state plan. Payment for non-medical transporation services is limited to the costs of transportation needed to access a waiver services included in the participant's service plan or access other activities and resources identified in the service plan. When the costs of transportation are included in the provider rate for another waiver service that the client is receiving at the same time, non-medical transportation services cannot be reimbursed under the waiver.

Minor Home Modifications, Adaptive Aids and Supports, Paraprofessional Services, Professional Services and Non-Medical Transportation have a collective limit of $5,000 annually.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*

Transportation providers must have a valid Texas driver's license appropriate to the vehicle used to provide transportation

Certificate *(specify):*

Other Standard *(specify):*

Transportation providers must be over age 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Paraprofessional Services

Service Definition *(Scope):*

Services related to addressing the waiver participant's needs that arise as a result of their severe emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the participants to avoid institutionalization. The services are essential to promote community inclusion in typical child/youth activities and exceed what would normally be avaiable for children in the community. Services include:

- Skilled mentoring and coaching - Skilled mentoring would be an individual who has had additional training/experience working with children/youth with mental health problems. For example, a teenager with severe behavior problems may require mentoring from an individual with behavioral management expertise.

- Paraprofessional Aide - This service may be reimbursed if delivered in a setting where provision of such support is not already required or included as a matter of practice. The aide assists the child in preventing and managing behaviors stemming from severe emotional disturbance that create barriers to inclusion in integrated community activities such as after-school care or day care.

- Job placement – assistance in finding employment

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Minor Home Modifications, Adaptive Aids and Supports, Paraprofessional Services, Professional Services and Non-Medical Transportation have a collective limit of $5,000 annually. Room and board, normal household expenses and items not related to amelioration of the child's disability are not included.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Paraprofessional Services

Provider Category:

Agency

Provider Type:
Agencies holding a Medicaid YES waiver provider agreement
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A paraprofessional (or community services specialist) must meet the following qualifications:
(A) have received:
(i) a high school diploma; or
(ii) a high school equivalency certificate issued in accordance with the law of the issuing state;
(B) have three continuous years of documented full-time experience in the provision of mental health rehabilitative services or case management services; and
(C) demonstrate competency in the provision and documentation of mental health rehabilitative or case management services in accordance with Title 25, Tex. Admin. Code Chapter 419, Subchapter L relating to Mental Health Rehabilitative Services and Chapter 412, Subchapter I relating to Mental Health Case Management Services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Professional Services
Service Definition *(Scope):*
Services to waiver recipients to assist them in meeting recovery goals. The intent of these services is to maintain or improve health, welfare, and/or effective functioning in the community. These services include:
- Art therapy
- Music therapy
- Animal-assisted therapy
- Recreational therapy
- Licensed nutritional counseling

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Minor Home Modifications, Adaptive Aids and Supports, Paraprofessional Services, Professional Services and Non-Medical Transportation have a collective limit of $5,000 annually. Room and board, normal household expenses and items not related to amelioration of the child's disability are not included.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Professional Services

Provider Category:

Agency

Provider Type:

Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*

Appropriately licensed professionals, relative to the specific service provided. These are: licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurses, physical therapists, occupational therapists or licensed nutritionists.

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Psychiatric Observation
Service Definition *(Scope):*
Services are provided in a facility which meets DSHS requirements as an Extended Observation Unit. Extended Observations Units (EOUs) provide emergency stabilization to individuals in a secure, accessible, protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordiated transfer to a higher level of care when needed. EOUs are available 24 hours a day, 7 days a week. Staffing includes a psychiatrist (who serves as the medical director), physicians, registered nurses, LPHAs, qualified mental health professionals, and behavioral health technicians.

DSHS requires that the physical plant for EOUs meet the following criteria:
• Be in a secure location.
• Be accessible and meet all Texas Accessibility Standards.
• Have provisions for ensuring environmental safety.
• Have a designated area where persons in extreme crisis can be observed and safely maintained until the crisis is resolved or the individual is transported to another level of care (e.g., hospital or crisis stabilization unit).
• Afford privacy for protection of confidentiality.
• Have separate child, adolescent, and adult observation areas.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
48 hours per crisis event

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Psychiatric Observation

Provider Category:
Agency
Provider Type:
Agencies holding a Medicaid YES waiver provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A facility which meets DSHS requirements as an extended observation facility and that complies with the DSHS crisis services extended observation standards.

Extended Observation Unit providers include:
* A physician, preferably a psychiatrist, on call 24 hours/day to evaluate individuals face to face or via telemedicine as needed;
* At least one licensed master's level clinician on site 24 hours/day, seven days/week;

* At least one RN on site 24 hours/day, seven days/week; and
* Behavioral health technician(s) on site 24 hours/day, seven days/week.

The staff Extended Observation Unit may also include licensed psychotherapists/counselors, licensed vocational nurses, certified nurse assistants, qualified mental health professionals and licensed nutritionist.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS

Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Supportive Family-based Alternatives

Service Definition *(Scope):*
Supportive Family-based Alternatives (SFA) are designed to provide therapeutic support to the child and to model appropriate behaviors for the child's family with the objective of enabling the child or adolescent to successfully return to their family and live in the community with their family. SFA includes services required for a waiver participant to temporarily reside within in a home other than the home of their family. The Child-Placing Agency will recruit, train and certify the support family and coordinate with the child or adolescent's family. The support family must include at least one adult living in the home and no more than four non-related individuals may live in the home. The support family must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence in the community and provide an environment that assures community integration, health, safety and welfare of the waiver participant. The support family must provide services as authorized in the individual participant's service plan. Services may include:

* Age and individually appropriate guidance regarding and / or assistance with the activities of daily living and instrumental activities of daily living (ambulating, bathing, dressing, eating, getting in/out of bed, grooming, personal hygeiene, money management, toileting, communicating, performing household chores and managing medications)
* Securing and providing transportation
* reinforcement of counseling, therapy and related activities
* assistance with medications and performance of tasks delegated by a registered nurse or physician
* Supervision of the individual for safety and security
* Facilitating inclusion in community activities, social interaction, use of natural supports, participation in leisure activities and development of socially valued behaviors
* Assistance in accessing community and school resources

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
SFA must be prior authorized by DSHS. Room and board is not included in the payment for SFA. Waiver participants are responsible for their room and board costs. A waiver participant may not receive Respite or Community Living Supports (CLS) while receiving SFA. Children and adolescents eligible for or receiving Title IV-E services cannot receive SFA. SFA may be authorized for up to 90 consecutuve or cumulative days per individual service plan year, with individual exceptions possible on a case-by-case basis, if recommended by the LMHA and prior approved by DSHS.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Family-based Alternatives

Provider Category:

Agency

Provider Type:

Agencies holding a Medicaid YES waiver provider agreement

Provider Qualifications

License *(specify):*

Child-Placing Agency licensed by the Texas Department of Family and Protective Services (DFPS)(TAC 40, Part 19, Chapter 749, Subchapter C)

Certificate *(specify):*

Other Standard *(specify):*

Individual providers must be age 18 or over and not the spouse or parent of the waiver participant; must have CPR and first aid training; pass a criminal background check, have a current Texas Driver's license and insurance (if transporting the waiver participant).

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency’s verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transitional Services
Service Definition *(Scope):*
A one-time non-recurring allowable expense when an individual transitions from an institution, provider-operated setting, or family home to their own private community residence. Assistance may include:
* utility and security deposits for the home/apartment
* needed houshold items such as linens and cooking utensils
* essential furnishings
* moving expenses
* Services necessary to ensure health and safety in the aprtment/home (e.g., pest erradication, allergen control, one-time cleaning)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transition assistance is limited to $2,500 dollars per waiver participant.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a Medicaid YES waiver provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:
Agency
Provider Type:
Agencies holding a Medicaid YES waiver provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Services will be provided by the waiver provider agency. The waiver provider agency must demonstrate to DSHS that services provided meet the requirements of the approved plan of care and are of reasonable cost.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

DSHS will also verify individual provider qualifications. Verification will occur when the waiver provider agency applies to provide waiver services and upon each renewal of the waiver provider agency agreement. DSHS will use a statistical sampling methodology to assure that the sample of individual provider qualifications accurately assesses the waiver provider agency's verification of individual provider qualifications. The sample size will produce results with a confidence level of 95 percent and a confidence interval of plus-or-minus 5 percent.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

It is delivered under the Medicaid State Plan as a targeted case management service by the community mental health center case manager.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) A criminal history check is conducted for all providers by the waiver provider agency prior to employment or assignment regardless of the activities the individual will be performing.

(b) The criminal history check utilizes a statewide database maintained by the Texas Department of Public Safety. If the individual lived outside the state of Texas at any time during the previous two years, then the criminal history check will include submission of fingerprints to the Federal Bureau of Investigations. An individual who has been convicted of any of the criminal offenses delineated in 25 TAC, Part 1, Chapter 414, Subchapter K may not be employed or serve as a volunteer or intern.

(c) The waiver service provider agency is required to maintain documentation of the criminal history checks. During the annual review, DSHS will monitor waiver service provider agencies for completion of criminal history checks as required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Texas maintains two statewide abuse and misconduct registries:
1) Nurse Aide Registry maintained by the Department of Aging and Disability Services (DADS)
2) Employee Misconduct Registry maintained by the Department of Aging and Disability Services (DADS).

(b) A registry check is conducted for all employees, volunteers, and contracted providers prior to employment or assignment regardless of the activities the individual will be performing. An individual who is listed as having a finding entered into the Nurse Aide Registry concerning abuse, neglect, or mistreatment of a consumer or misappropriation of property may not be employed or serve as a volunteer or intern. An individual who is listed in the Employee Misconduct Registry as having abused, neglected, or exploited a consumer may not be employed or serve as a volunteer or intern.
(See Texas Health and Safety Code Sections 250.003 and 253.008.)

(c) The Waiver Provider Agencies are required to conduct screening against the relevant registry. During the annual review, DSHS will monitor the Waiver Provider Agencies for completion of registry checks as required.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Respite services may be provided by a relative of the waiver recipient other than the natural or adoptive parents or legal guardian. The relative must be at least 18 years of age, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2. If respite services are provided in the relative's home, the relative must have a functional landline phone on the premises. The relative provider is required to complete the same training required by DSHS of all respite providers.

  To receive payment for the provision of respite services the following criteria must be met:

  Prior to the provision of the respite services the waiver recipient's plan of care must identify the need for respite services and the relative as a provider of respite services

  After the provision of the respite services the LAR must sign a form indicating the date(s), time, and duration of the provision of the respite services. The form will also include a statement as to the location of service provision (e.g., relative's home, waiver recipient's home).

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Waiver Provider Agencies must contract with the single state Medicaid agency and its operating department/division DSHS. DSHS will manage the provider enrollment process. A qualified provider may submit an application at any time. DSHS will post information on the provider agency enrollment process and requirements on the electronic state business daily and send periodic notices to provider associations, communities and advocacy groups. In addition, providers may contact DSHS directly at any time during the year to obtain an application. Qualified YES waiver provider agencies agree to provide all YES Program services.

This model of service delivery accomplishes the following for YES Program consumers:

* ensures the availability of each service component in all counties included under the waiver;

* recognizes that a vast majority of consumers are not single service users, but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;

* promotes effective response to temporary or permanent changes in consumers' service needs as provider agencies are required to make all services components available when and as they are needed by consumers;

* establishes a single point of accountability for provision of needed services; and

* decreases administrative costs.

In addition to promoting efficient service delivery, the YES Program service delivery model does not compromise a consumer's choice of qualified provider agencies or providers of individual service components. Provider agencies are enrolled in the YES program through an open enrollment process, which includes all willing, qualified provider agencies. In the included counties,

consumers have a choice between at least two provider agencies.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.1. Percent of waiver provider agencies that have a credentialing process in place to verify that providers meet required licensing or certification standards for provision of contracted waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.2. Percent of waiver providers that meet required licensing or certification standards for provision of contracted waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.3. Percent of waiver provider agencies with a process in place that results in selection of qualified non-licensed providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval = [ ]
☐ Other Specify: [ ]	☑ Annually	☐ Stratified Describe Group: [ ]
	☐ Continuously and Ongoing	☐ Other Specify: [ ]
	☐ Other Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: [ ]	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify: [ ]

Performance Measure:
C.4. Percent of nonlicensed waiver providers that meet required standards for provision of contracted waiver services.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.5. Percent of waiver provider agencies that complete the required state waiver training.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify: [ ]

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency retains administrative authority over the waiver program. HHSC is actively involved in development of and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of quality assurance activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by

the State to document these items.
Training and technical assistance is provided by the DSHS Quality Management Unit initially and on an ongoing basis. A quarterly risk assessment is also conducted by the Quality Management Unit. If problems are identified, DSHS will do a review and report to the waiver provider agency. A plan of improvement will be developed by the waiver provider agency and approved by DSHS. If the plan is not followed and improvements are not implemented, the Quality Management Unit refers the problem to the DSHS Mental Health Substance Abuse contract unit for remedial action and possible sanctions.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

  The following services will be limited to an annual maximum of $5000: professional, paraprofessional, Adaptive Aids and Supports, minor home modifications and non-medical transportation. The family and youth will choose those services that will most support the youth's recovery goals specified in the plan of care. This limit was based on historical expenditures for comparable programs in Texas. The LMHA will inform waiver participants and LARs of the limits upon enrollment and will refer participants to other community and state resources as needed.
- **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.
- **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- **Registered nurse, licensed to practice in the State**
- **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- **Licensed physician (M.D. or D.O)**
- **Case Manager** (qualifications specified in Appendix C-1/C-3)
- **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

  Case management is delivered as a state plan service.

  Case Managers will have the following qualifications:

A case manager has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention,
OR
as of August 31, 2004, has received a high school diploma or equivalency certificate, three continuous years of documented full time experience in the provision of mental health case management services, and demonstrated competency in the provision and documentation of case management services.

☐ **Social Worker.**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

In Texas, a community mental health center may also be waiver provider agency as a last resort when there are no other provider agencies available in a locality or if the existing provider agencies do not have sufficient capacity. If the state contracts with a community mental health center to be a waiver provider agency, DSHS will conduct an initial review prior to implementation and annual reviews as part of its oversight responsibilities to ensure full disclosure, right of free choice of providers, and provision of sufficient information regarding waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) At intake the waiver recipient and LAR are informed of their rights and given the DSHS "Handbook of Consumer Rights." This handbook documents the waiver recipient's and representative's right to participate in the development of the plan of care. The documentation includes the waiver recipient's right to request that other individuals be involved and the waiver recipient's right to an explanation should the request be denied. The waiver recipient and LAR will also be informed of the conditions in which the right to request a Medicaid Fair Hearing apply.

(b) Per Texas Administrative Code, the local mental health authority, case manager, and provider must include information obtained from the waiver recipient and the LAR regarding the waiver recipient's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for and objections to specific treatment. The local mental health authority, case manager, and provider must also identify the representative's or family member's needs for education and support services related to the waiver recipient's emotional disturbance and facilitate the representative's or family member's receipt of the needed education and support services. The case manager and provider must involve the waiver recipient and the LAR in all aspects of planning the waiver recipient's treatment. If the waiver recipient has requested the involvement of additional family members, then the provider

must involve the family member in all aspects of planning the waiver recipient's treatment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The waiver will utilize an individualized planning process that addresses the waiver recipient's unmet needs across all life domains. According to the ten principles of the planning process, the family is a full active partner and the expert on the waiver recipient and family. The family selects the treatment team members. Team membership is as open as the family chooses and may include other service providers, neighbors, clergy, and other individuals who currently do, or may in the future, provide support to the family. If the family agrees, the team membership also includes an employee designated as a "Family Supports Staff" (The Family Supports Staff is an experienced parent or caregiver of a child or adolescent with a serious emotional disturbance who provides peer mentoring to the family and assists with engaging the family into services.) The waiver recipient and family are included in all decision making. The initial plan development occurs in phase two of the process, after the team has met, been oriented to their role on the team, identified family strengths through "Family Strengths Discovery," and developed the crisis and safety plan.
(b) The CA-TRAG is a broad measure of the waiver recipient's current functioning. More detailed information is obtained through "Family Strengths Discovery." The discovery process focuses on the development of functional strengths and assets rather than the elimination of deficits. The process is responsive to cultural issues and the family's preferences and overarching goal for the waiver recipient.
(c) The waiver recipient and family will be informed of the services offered under the waiver at the time the local mental health authority has determined that the child or adolescent may qualify to receive services under the waiver. The local mental health authority staff person will also inform the waiver recipient and family of other treatment options such as hospitalization.
(d) The team, which includes the waiver recipient and family, prioritizes the waiver recipient's top 3-5 needs. The team develops a measurable outcome for each prioritized need. The team decides how each outcome will be measured. Outcome statements are chosen by the waiver recipient and family. Multiple strategies are generated and evaluated for the extent to which they will meet the prioritized need, achieve the measurable outcome, are community-based, are built on or incorporate strengths, and are consistent with the family's values and culture. The selected strategies are based on the waiver recipient and family's preferences.
(e) The case manager will have the responsibility of coordinating the agreed upon services and supports.
(f) The team assigns responsibility for completion of the action steps associated with each strategy. The case manager's responsibilities will include monitoring compliance to the plan by all members of the team.
(g) The plan will be reviewed at least every 90 days. More frequent review may be required to address significant life events or changes in the waiver recipient's or family's functioning.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Because these youth are at high risk of placement for mental health treatment or are returning from such placements, crisis plans are developed at the first meeting of the treatment teams. Treatment team membership includes the waiver recipient and caregiver to ensure that the waiver recipient's and family's needs, strengths, and preferences are taken into consideration. Crisis plans are incorporated into the plan of care with all team members knowing the roles they will play when crises arise. This approach to crises helps prevent crises and ensures crises are addressed immediately. If the waiver recipients have safety or transition issues, safety and transition plans are also developed at the first meeting of the treatment teams and incorporated into the plan of care. When safety plans are needed, the safety of the waiver recipient and all other family members must be addressed to the satisfaction of all team members.

The service plan will include contingency plans for back-up of services as well as a back up targeted case manager (QMHP), with their contact information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon determination of eligibility, the local mental health authority will provide the waiver recipient or LAR with a list of all waiver provider agencies within the geographic limitation identified in item 4.C. of the waiver application. This list will also be provided annualy at plan renewal and any time upon request of the participant or LAR. The community mental health center case manager will assist the individual in contacting providers and involving providers, as appropriate in the development of the individual plan of care.

The provision of the provider agency list and the final selection of a provider agency must be documented and retained in the waiver recipient case record. DSHS will conduct periodic reviews to ensure that the LMHA objectively assists the waiver recipient and LAR in the process of selecting a provider agency. DSHS will provide a list of qualified provider agencies to the LMHA and wil provide updates to this list at least annually, at plan of care renewal or anytime upon request.

The waiver recipient's right to choose the service provider extends to the specific agency personnel that will be providing waiver services. The waiver recipient's and LAR's selection of agency personnel will be documented and retained in the waiver recipient case record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DSHS approves each individual plan of care and approves all criteria, processes, and documentation requirements related to the plan of care.

HHSC Medicaid / CHIP Division will oversee DSHS in its role as operating department/division and will participate with DSHS in at least one site review per year. HHSC staff will monitor compliance with the operating agreement between HHSC and DSHS. HHSC will also review the methodology used for pulling samples, and the process used to assure that it is representative and unbiased.

DSHS will use a formula for determining the sample size that is designed to provide reliable and valid information at the LMHA level. A minimum of 22 consumers per LMHA, per sample period will be reviewed.

DSHS staff reviews each sampled record's service plan to verify that medical necessity determination has been met and that any applicable service limitations have not been exceeded.

HHSC will, through the operating agreement with DSHS, delineate roles and responsibilities. The operating agreement outlines HHSC's monitoring and oversight functions. HHSC will delegate the day-to-day approval of individual service plans to DSHS. DSHS will approve all individual service plans. DSHS also will perform at least annual reviews of the LHMAs. DSHS will aggregate the data annually and report to HHSC. HHSC will discuss any significant findings with DSHS and together with DSHS prepare a remediation plan or improvement plan as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

  Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

  Specify:

  The waiver service provider agency, if applicable

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers will monitor the day to day implementation of the individual plan of care, waiver recipient health and welfare, and assess how well services are meeting a waiver recipient's needs and enabling the waiver recipient to achieve the stated goals and outcomes. The case manager must meet in person with the waiver recipient at least once every 90 days. The case manager must have at least one contact with the LAR every 90 days. The purpose of the required contacts is to verify the following:
the safety and crisis plans are working as intended;
services and supports are being implemented and provided in accordance with the plan of care and continue to meet the waiver recipient's needs, goals, and preferences;
the waiver recipient and LAR are satisfied with the implementation of services;
the waiver recipient's health and welfare are reasonably assured; and
the waiver recipient or LAR exercises free choice of providers and accesses non-waiver services including health services.
The CMHC's quality management and supervisory staff will provide oversight to the case manager's efforts ensuring that the required contacts occur, modifications to the plan of care occur as necessary, and that the documentation generated by the case manager provides evidence of compliance with the requirements.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

  The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
  Specify:

  DSHS will conduct annual reviews of the waiver provider agencies. The reviews will include an evaluation of the waiver recipient case records to ensure that the provider agencies are providing adequate oversight and that the provider agency is responsive to findings.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods

for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.1. Percent of individual plans of care evidencing that the waiver recipients' plans of care reflect the assessed needs and personal and family goals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.2. Percent of individual plans of care evidencing that the waiver recipient's plan of care is developed in accordance with waiver policies and procedures.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.3. Percent of individual plans of care evidencing that the waiver recipient's plan of care is updated at least annually or when warranted by changes in waiver recipient's needs or goals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.4. Percent of individual waiver participant records evidencing that services included in the plan of care are provided in the amount, duration and scope specified in the plan, or that justification is provided as to the reason that a service is not provided, such as a change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.5. Percent of individual participant records that evidence that waiver recipients were provided choice between waiver community services and institutional care and choice of waiver provider agencies and of individual waiver providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that applies):*	**Frequency of data aggregation and analysis** (*check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency retains administrative authority over the waiver program. HHSC is actively involved in development of the waiver and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of quality assurance activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding

responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Training and technical assistance are provided by the DSHS Quality Management Unit initially and on an ongoing basis. A quarterly risk assessment is also conducted by the Quality Management Unit. If problems are identified, DSHS will conduct a review and report to the waiver provider agency and community mental health center. A plan of improvement will be developed by the waiver provider agency and community mental health center and approved by DSHS. If the plan is not followed and improvements are not implemented, the Quality Management Unit refers the problem to the DSHS Mental Health Substance Abuse contract unit for remedial action and possible sanctions.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the intake process the local mental health authority will inform the youth and LAR of the youth's right to a Fair Hearing. If the youth or LAR needs any assistance with the fair hearing process, the case manager will provide assistance.

Once the request is processed, it is forwarded to the appropriate HHSC regional office.

The following explains the process used by the local mental health authority when there is a request for a Fair Hearing.

The local mental health authority will use a standardized DSHS-generated letter stating the conditions under which the youth may request a Fair Hearing:

- If found to be eligible for the waiver, the youth was not given the choice of waiver services as an alternative to institutional care;
- The youth was not given the opportunity to receive services from the provider the child or adolescent chose; or
- Waiver services were denied, suspended, reduced, or terminated.

A youth whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness, or a waiver recipient whose waiver services have been terminated, suspended, or reduced by DSHS, is entitled to a fair hearing in accordance with Texas Administrative Code. DSHS provides written notification to the youth and LAR, indicating the youth's right to a fair hearing and the process to follow to request a fair hearing. The notice informs the youth as to the right to continue to receive services while the hearing is pending and the actions the youth must take for services to continue. Individuals submit the Request for a Fair Hearing to DSHS. DSHS then requests that HHSC assign a Fair Hearing Officer.

All notification letters and request forms are offered in both English and Spanish.

DSHS retains a copy of the notice of adverse action taken by DSHS and the notice to the youth and LAR of the right to a Fair Hearing. If a youth or LAR requests a Fair Hearing, a copy of the written request for a hearing is retained as well.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DSHS operates the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DSHS Consumer Services and Rights Protection Unit staff operate an 8am to 5pm toll free phone line with TTY capabilities during the work week. Complaints can also be submitted via email or written correspondence. Complaints may be anonymous. (a) There is no restriction on the types of complaints that waiver recipients may register. (b) All complaints are acted upon immediately. Given the variety of complaints, there is no mandated time line for resolution to the complaint. (c) Consumer Rights and Protection Staff have access to all departments and units to resolve the waiver recipient's complaint.

Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the department with statutory responsibility for investigation of such allegations.

HHSC's Office of the Ombudsman assists the public when DSHS' normal complaint process cannot or does not satisfactorily resolve an issue. The waiver recipient and their families also have the option of contacting the Office of the Ombudsman directly for assistance. The Ombudsman's services include:
• Conducting independent reviews of complaints concerning agency policies or practices;
• Ensuring policies and practices are consistent with the goals of HHSC;
• Ensuring waiver recipients are treated fairly, respectfully and with dignity; and
• Making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:
1. Member of the public, individual, or provider makes first contact with HHSC or with DSHS to request assistance with an issue or complaint.
2. If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted.
3. The Office of the Ombudsman will provide an impartial review of actions taken by the program or department.
4. The Office of the Ombudsman will seek a resolution and may use mediation if appropriate. Often it is necessary for the Office of

the Ombudsman to refer an issue to the appropriate department. If so, the Office of the Ombudsman will:
o Follow-up with the complainant to determine if a resolution has been achieved.
o Refer complainant to other available known resources.

Waiver recipients will be given the contact information for DSHS Consumer Rights and Protection, DFPS, and the Office of the Ombudsman at intake, when requested, and when a need is identified or thought to exist.

Waiver services recipients are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver provider agency contracts and community mental health center contracts include requirements to report any incidents that result in substantial disruption of program operation involving or potentially affecting persons served to the DSHS Contract Management Unit within 72 hours.

For ANE reports the waiver provider agencies and community mental health centers are required to submit accurate and timely information to DSHS in accordance with the Submission Calendar, as follows: Within one business day after completion of the Client Abuse and Neglect Reporting Form, AN-1-A, the information contained in the completed form, or if online access is unavailable, a copy of the completed form is sent to the DSHS Office of Clients Rights and Services.

In an instance where the contractor must report abuse or neglect, investigations are conducted by the Department of Family and Protective Services (DFPS). DFPS submits a copy of the investigative report to DSHS and the director of the waiver provider agency or community mental health center.

The director may not change a confirmed finding made by a DFPS investigator. The director may request a review of the finding or the methodology used to conduct the investigation.

If the perpetrator or alleged perpetrator is an employee or agent of the waiver provider agency or community mental health center, the director shall ensure that the employee or agent is removed as a provider of services from the individual.

A Client Abuse and Neglect Reporting form (AN-1-A) is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the Client Abuse and Neglect Reporting System (CANRS) Definitions and Classifications. Within one working day after completion of the AN-1-A form, the administrator shall ensure that:

(1) the information contained in the completed AN-1-A is entered into CANRS; or

(2) if access to CANRS is unavailable, a copy of the completed AN-1-A is forwarded for data entry to the DSHS Office of Consumer Services and Rights Protection.

All waiver recipients, LARs, waiver provider agencies and community mental health centers are provided with the DFPS toll-free telephone number in writing and are instructed to report to DFPS immediately, but not later than one hour after having knowledge or suspicion, that a waiver recipient has been or is being abused, neglected, or exploited. Community mental health centers and waiver

provider agencies are required to train staff on identifying, preventing, and reporting abuse, neglect and exploitation.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of admission into waiver services the waiver recipient and the LAR will be informed of the process for reporting allegations of abuse, neglect or exploitation and given the toll free number for DFPS. Oral and written communication of this information will be documented on a form bearing the date and signatures of the waiver recipient and/or LAR and the staff person who provided this information. The form will be filed in the waiver recipient's case record with a copy for the LMHA's records.

The waiver recipient and LAR will also be given a copy of DSHS's "Handbook of Consumer Rights, Mental Health Services" in either English or Spanish as appropriate. In addition to receiving the rights handbooks, the waiver recipient and LAR will be informed orally of all rights in his or her primary language using plain and simple terms. The method used to communicate the information will be designed for effective communication, tailored to meet each person's ability to comprehend, and responsive to any visual or hearing impairment. Oral communications of rights will be documented on a form bearing the date and signatures of the waiver recipient and/or LAR and the staff person who explained the rights. The form will be filed in the waiver recipient's case record. The provider will repeat the explanation of rights, including giving the waiver recipient a copy of the handbook and required documentation, at least annually.

The name, telephone number, and mailing address of the provider's rights protection officer will be prominently posted in every area that is frequented by service recipients. Waiver recipients desiring to contact the rights protection officer must be allowed access to the provider's telephones to do so.

Critical incident training for waiver providers will be provided by waiver provider agencies.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical incidents are managed as part of the contract oversight process by DSHS. When the Quality Improvement unit does a comprehensive review of waiver provider agencies, local mental health authorities or community mental health centers, critical incident reports are reviewed. A comprehensive review of a contractor is triggered by factors discovered in the risk analysis.

If the perpetrator or alleged perpetrator is an employee or agent of a local authority, community center, or contractor, or the perpetrator is unknown, then the administrator of the local authority, community center, or waiver provider agency shall ensure that a Client Abuse and Neglect Reporting form (AN-1-A) is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the CANRS Definitions and the CANRS Classifications. Within one working day after completion of the AN-1-A form, the administrator shall ensure that:

(1) the information contained in the completed AN-1-A is entered into the Client Abuse and Neglect Reporting System (CANRS); or

(2) if access to CANRS is unavailable, a copy of the completed AN-1-A is forwarded for data entry to the DSHS Office of Consumer Services and Rights Protection.

Critical incidents related to ANE are also reported to Child Protective Services at DFPS if a parent is involved or law enforcement if the alleged perpetrator is not a parent.

DFPS receives allegations of abuse, neglect and exploitation of waiver recipients from waiver providers. DFPS is statutorily responsible for review, investigation and response to those reports. Depending on the severity of the allegation, DFPS investigations must be completed with 14 to 21 days. Investigation results are provided to the participant or LAR, in writing, no later than 15 days after the investigation is closed by the supervisor.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DSHS is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect waiver participants. DSHS conducts risk assessment of the community mental health centers and waiver provider agencies quarterly which includes a review of any reported criticial incidents and events. DSHS will report data from critical incident reviews to HHSC on at least an annual basis.

The Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported to HHSC via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, to develop and monitor remediation plans.

In the case of critical incidents, waiver provider agencies are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  Per Texas Administrative Code (TAC), the use of chemical restraint is prohibited. The use of mechanical restraints and seclusion are also prohibited.

  The TAC defines personal restraint as, “The application of physical force alone restricting the free movement of the whole or a portion of the waiver recipient’s body to control physical activity." Personal restraint is used only as last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the waiver recipient or others from harm. The intervention is used for the shortest period possible and terminated as soon as the waiver recipient demonstrates the release behaviors specified by the ordering physician.

  Waiver providers shall be trained in the safe use of personal restraint by the waiver provider agencies. Providers shall not use personal restraint unless it is necessary to intervene to prevent imminent probable death or substantial bodily harm to the participant or imminent physical harm to another, and less restrictive methods have been tried and failed.

  Providers shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of clients who are personally restrained, including attention for personal needs.

  The provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the initial assessment of each client at the time of admission or intake. This information includes, but is not limited to:

  (A) techniques, methods, or tools that would help the client effectively cope with his or her environment;

  (B) pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the client at greater risk during restraint;

  (C) any history of sexual or physical abuse that would place the client at greater psychological risk during restraint; and

  (D) any history that would contraindicate restraint.

  A client held in restraint shall be under continuous direct observation. The provider shall ensure adequate breathing and circulation during restraint. An acceptable hold is one that engages one or more limbs close to the body to limit or prevent movement.

  Provider shall record the following information in the client record within 24 hours:

  * the circumstances leading to the use of personal restraint;

* the specific behavior necessitating the restraint and the behavior required for release;

* less restrictive interventions that were tried before restraint began;

* the names of the providers who implemented the restraint;

* the date and time the procedure began and ended; and

* the client's response.

A prone or supine hold shall not be used except as a last resort when other less restrictive interventions have proven to be ineffective. The hold shall be used only to transition a client into another position, and shall not exceed one minute in duration. Except in small residential facilities, when the prone or supine hold is used, an observer, who is trained to identify the risks associated with positional, compression, or restraint asphyxiation and with prone and supine holds, and who is not involved in the restraint, shall ensure the client's breathing is not impaired.

The family or LAR must be notified each time restraint is used. The use of restraint must be reported daily to waiver provider agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DSHS is responsible for overseeing the use of personal restraints by Waiver providers. The use of mechanical restraints and seclusion is prohibited in community settings. For residential treatment settings, DFPS is responsible for oversight of restraint and seclusion.

The oversight of personal restraint for waiver provider agencies is accomplished through the quarterly risk assessment conducted by DSHS. The use of personal restraint must be documented as a critical incident by the waiver provider agencies and community mental health centers and follow the procedures specified in Appendix G-1 for Critical Incident Reporting.

Unauthorized use of restraint and seclusion will be detected by record review and through complaints.

The Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported to the State Medicaid Agency, which is within HHSC, via these indicators and associated reports. At a minimum, HHSC will coordinate with DSHS no less than annually through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

In the case of critical incidents, waiver provider agencies are expected to take immediate action to resolve, when feasible, and to report to appropriate state and law enforcement entity.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

There are no other restrictive interventions permitted other than the personal restraint specified in Appendix G-2:a.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Residential Treatment Facilities: DFPS is responsible for licensing and regulating Residential Treatment Facilities in Texas. DFPS staff enforce these rules through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually. Minimum Standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

Other waiver providers: The waiver provider agency will be responsible for ensuring that waiver providers act within the scope of their respective licenses in relation to medication management. If the plan of care includes medication management activities, the waiver provider agency will document these activities in the waiver recipients case records. Any errors must be reported to DSHS as critical incidents.

Second line monitoring is conducted through an on-going process of retrospective analysis of the Medicaid utilization data by DSHS

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Residential Treatment Facilities: DFPS conducts inspections and monitors the facilities and reviews for compliance with minimum standards and contract requirements related to medications by assessing clinical records, medication logs and other documentation of medication. Identification of harmful practices are reported to DFPS and appropriate corrective actions are taken to bring facilities back into compliance. DFPS also provides technical assistance on meeting and maintaining standards and achieving quality in child care.

Other waiver providers: DSHS conducts surveys and monitors providers for compliance with licensing requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the facility back into compliance. DSHS includes medication management review as part of its quarterly risk review of contracted waiver provider agencies.

In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency retains administrative authority over the waiver program. HHSC is actively involved in development of and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which will outline the frequency of each agency's activities. HHSC and DSHS will analyze data regarding each assurance through reports presented at Quality Review Team meetings no less than annually, and when potentially harmful practices are identified, will develop remediation or improvement plans, as needed. In the case of medication

management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For Residential Treament Facilities: DFPS Minimum Standard rules for residential child care facilities are found in Chapters 748 and 749 of the Texas Administrative Code. Minimum Standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

For other waiver providers:

• The waiver provider must be qualified under the scope of their licensure to administer medications.
• The parent or LAR must sign an authorization for the waiver provider to administer each medication according to label directions.
• The medication must be in the original container labeled with the waiver recipients' full name and expiration date.
• The waiver provider must administer the medication according to the label directions or as amended by a physician.
• The waiver provider must administer the medication only to the waiver recipient for whom it is intended.
• The waiver provider must not administer the medication after its expiration date.
• The waiver provider may provide non-prescription medications if the obtains consent from the parent or LAR prior to administration of the medication. Consent may be given over the phone and documented as such by the respite provider.
• The waiver provider must document the following:
- Full name of the waiver recipient to whom the medication was given,
- Name of the medication,
- Date, time , and amount of medication given, and
- Full name of individual provider administering the medication.
• All medication records must be kept for three months after administering the medication.
• The provider must store medications as follows:
- Out of reach of children or in locked storage
- In a manner that does not contaminate food
- Refrigerate if require and kept separate from food.
• Unused prescription medications are to be returned to the parent or LAR.

Self-administration of medications may occur under the supervision of a waiver provider. The provider must ensure:
• The parent or LAR has signed an authorization for the waiver recipient to self-administer each medication according to label directions.
• The medication must be in the original container labeled with the waiver recipients' full name and expiration date.
• The waiver recipient administers the medication in amounts according to the label directions or as amended by a physician.
• The waiver recipient must administer the medication only to him or herself.
• The waiver recipient must not administer the medication after its expiration date.
• The waiver recipient may provide self-administer non-prescription medications if the waiver provider obtains consent from the parent or LAR prior to the self-administration of the medication. Consent may be given over the phone and documented as such by the respite provider.
• The waiver provider must document the following:

- Full name of the waiver recipient who self-administered the medication,
- Name of the medication,
- Date, time , and amount of medication given, and
- Full name of waiver provider supervising the self-administration of the medication.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

DSHS

(b) Specify the types of medication errors that providers are required to *record:*

Medication given to the wrong person, giving the person the wrong medication, giving the incorrect dosage, failing to give the medication at the correct time, failing to use the correct route, or failing to accurately document the administration of the medication

(c) Specify the types of medication errors that providers must *report* to the State:

Medication given to the wrong person, giving the person the wrong medication, giving the incorrect dosage, failing to give the medication at the correct time, failing to use the correct route, or failing to accurately document the administration of the medication. All medication errors are reported as critical incidents by the waiver provider agencies.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Residential Treatment Facilities: DFPS is responsible for monitoring the performance of providers administering medications to waiver partipants. DFPS staff enforce
requirements through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually.

Other waiver providers: DSHS is responsible for monitoring the performance of providers administering medications to waiver partipants. DSHS staff enforce requirements through quarterly risk assessment and review of critical incidents.

The waiver provider agencies are responsible for reporting medication errors to DSHS through the critical incident reporting process. Medication errors are monitored through the DSHS quarterly risk assessment process.

In accordance with 42 CFR Sec. 431.10 (e), the single state Medicaid agency retains administrative authority over the waiver program. HHSC is actively involved in development of and will provide final approval of the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations will be coordinated with and be approved by HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which will outline the frequency of each agency's activities. HHSC and DSHS will analyze data regarding each assurance through reports presented at Quality Review Team meetings no less than annually, and when potentially harmful practices are identified, will develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.1. Percent of waiver providers who are trained and knowledgable of acts constituting abuse, neglect, or exploitation (ANE), the requirements to report allegations of ANE, and methods to prevent ANE.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

Performance Measure:
G.2. Percent waiver providers for whom a criminal background check was conducted prior to serving waiver recipients.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

Performance Measure:
G.3. Percent of waiver recipients, families and LARs who were informed regarding how allegations of ANE are reported.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

Performance Measure:
G.4. Percent of critical incidents in which waiver provider agencies followed the contractually required process for responding to critical incidents.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation(*check each that applies):*	**collection/generation**(*check each that applies):*	*each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.5. Percent of program providers reporting critical incidents within state required time frames.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation(*check each that applies):*	**Frequency of data collection/generation**(*check each that applies):*	**Sampling Approach**(*check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.6. Percent of individual participants reviewed evidencing the waiver recipient or LAR was informed orally and in writing of the process for filing complaints.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported to HHSC by DSHS via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Training and technical assistance is provided by the DSHS Quality Management Unit initially and on an ongoing basis. A quarterly risk assessment is also conducted by the Quality Management Unit. If problems are identified, DSHS will conduct a review and report to the waiver provider agency and community mental health centers. A plan of improvement will be developed by the waiver provider agency and community mental health centers and approved by DSHS. If the plan is not followed and improvements are not implemented, the Quality Management Unit refers the problem to the DSHS Mental Health Substance Abuse contract unit for remedial action and possible sanctions.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

As this waiver is new, the Quality Improvement Strategy is not yet developed. This strategy will include current infrastructure utilized by Resiliency and Disease Management (RDM), the state's evidence-based mental health service delivery system. RDM includes uniform consumer assessment resulting in a LOC, evidence-based service packages, utilization management guidelines, quality management standards, and data management systems, including the state's data warehouse. Using the current processes as a framework, the state will develop a Quality Management Plan for this new waiver prior to the waiver effective date of September 1, 2009.

A Quality Review Team will be established by January 2009 and will consist of representatives from DSHS and HHSC. The team will meet routinely to monitor trends, prioritize improvement activities, develop or approve remediation plans, assess effectiveness of improvement activities, and report on quality processes and outcomes.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The state is developing its quality improvement strategy for this new waiver. Key elements of the waiver will be incorporated into the current quality management system to evaluate the effectiveness of this waiver.

The primary objective of the DSHS' Quality Management Unit is to administer a quality system that ensures that the state meets each required CMS assurance, identifies and acts on opportunities for improvement, and reflects values and principles common across programs. The Unit is designed to respond continually to findings and conditions related to participants, programs, providers, and administration of home and community-based services programs.

The Quality Management Plan will include a comprehensive list of data sources and reports related to this waiver. It will also identify report frequency and distribution, including communication to all stakeholders. Some current data sources include:

* The Client Assignment and Registration System (CARE) System. The computer based CARE system is used to collect, process, and report information about the waiver and can generate a wide variety of management reports. Critical incident statistics are retained in the CARE System to identify data measures that appear outside of expected parameters for critical incident data to assist in the identification of possible focal areas of the provider's compliance with the waiver.

* The State has developed a data warehouse that compiles data currently collected in multiple automated systems. The Data Warehouse produces standardized reports and provides capability for ad hoc reporting. The areas covered by the reports include: participant demographics; service utilization; enrollments; levels of care; service plans; consumer-direction; critical incidents; provider compliance and oversight: claims; transfers; and discharges. This system has the capability to provide management reports at the participant level or any level of aggregation needed.

* The Promoting Independence Advisory Committee (PIAC) is comprised of member representatives from all departments of the State Medicaid agency and external stakeholders. The PIAC studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities.

* On-site Program Provider Reviews. At least one annual on-site review of each program provider to evaluate compliance with the waiver policies. Intermittent reviews will also be conducted if a pattern of unresolved complaints or critical incidents is detected or if a provider's past performance warrants more frequent review.

* Desk Reviews. DSHS staff will conduct desk reviews for any requests made by the program provider for prior authorizations.

* Allegations of Abuse, Neglect, and Exploitation Review. DFPS will provide DSHS copies of each investigation of ANE allegations involving an individual enrolled in the waiver Program. Regardless of the investigation findings, DSHS reviews each investigative report.

As part of the ongoing development of Quality Improvement Strategy, the state will prepare an annual report based on discovery findings and including key information relevant to each assurance as well as information about participation in and the cost of the waiver. This report will provide the Quality Review Team and external stakeholders with information on quality indicators, including status of remediation and improvement activities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Management processes precipitate the need for on-going changes in policy, priorities, and activities. The Quality Review Team will evaluate the Quality Management Plan at least once during the waiver period. Changes to the Quality Management Plan will be communicated through the CMS-372 report.

The intent of quality management remains constant: to maintain accountability for public resources; to ensure the health and welfare of the participants; and to support individual choice and control.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Only those costs allowable under Texas' Uniform Grants Management Standards (UGMS) are allowable costs under the waiver. Applicable cost principles, audit requirements, and administrative requirements include:
Applicable Cost Principles – OMB Circular A-87, State, Local & Tribal Governments
Audit Requirements – OMB Circular A-133 and UGMS
Administrative Requirements – UGMS.

The provider shall obtain a comprehensive financial and compliance audit for the previous state fiscal year. The provider will submit four copies of the audit to DSHS and one copy to the Office of the Inspector General, Single Audit, HHSC, Office of Inspector General, Compliance / Audit, mail Code 1326, P.O. Box 85200, Austin, TX 78708. The provider will not engage the same audit firm for more than 6 consecutive years.

The Texas State Auditor's Office is responsible for the statewide financial and compliance audit. The Office of Inspector General is responsible for performing audits on contracts between DSHS and providers.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.1. Percent of paid waiver provider agency claims reviewed that are in accordance with waiver reimbursement methodology.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: semi-annual	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Financial Accountability

The Department of State Health Services contracts with local mental health authorities to deliver services across Texas.

Local mental health authorities (LMHAs) are non profit governmental entities and as such are required to have annual independent audits by external qualified firms. Verification of internal controls is an integral part of the audits.

Annual audit reports are received by the Department of State Health Services no later than the February following the close of each state fiscal year. In addition to measuring fiduciary compliance, the audit reports are used to assure fund expenditures and reconcile fund balances.

The Department of State Health Services' Contract Oversight Unit reviews quarterly local mental health authority financial statements.

The Department of State Health Services' Contract Quality Management Unit does quarterly risk assessments and issues quarterly Risk Assessment Reports. If Quality Management identifies problems of service delivery and billing, onsite reviews are conducted to evaluate billing and internal controls.

DSHS uses a the Medicaid Claims Oversight Review and Evaluation (Medicaid CORE) section of the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) to review every paid claim by Mental Health Medicaid providers.

Providers are required to monitor Medicaid CORE reports that indicate paid claims without authorizations, as well as claims that do not have supporting encounters in MBOW. Providers are required to repay any identified overpayment; DSHS conducts yearly recoupment of any identified overpayments that are not repaid. DSHS will perform desk reviews of samples from those claims identified as paid correctly.
DSHS conducts semi-annual reviews of reported service encounters to verify the validity of the service. Encounters are linked to paid claims and any identified invalid services are expected to be repaid by the providers. These data verification reviews include verification of diagnosis, treatment plan, medical necessity, server credentials, as well as service documentation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by

the State to document these items.
Medicaid CORE reports and Data Verification reports are used to inform the DSHS Risk Assessment process. The Risk Assessment process is used to identify providers that may have billing and financial problems.
Providers identified as being a high risk, either through routine Medicaid CORE reports, through Data Verification, or as a result of the Risk Assessment process are selected for comprehensive on-site reviews of their service delivery, billing practices and internal controls.
If a provider fails to comply with DSHS directives related to Medicaid services, DSHS may perform an on-site comprehensive review of selected services and direct that Medicaid payments be recouped proportionate to the error-rate identified.
Any findings that indicate waste, fraud or abuse are referred to the Office of the Inspector General.

Additionally, the Quality Oversight Plan will delineate specific indicators related to each sub-assurance. Data from these reviews will be reported by DSHS to HHSC, via these indicators and associated reports. HHSC will coordinate with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, develop and monitor remediation plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annual

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
HHSC and DSHS are developing an operating agreement that delineates the roles and responsibilities of each agency with regard to the YES waiver. The agreement will be in place by January 1, 2009. HHSC's Long-Term Supports and Services (LTSS) Policy Unit is directly responsible for monitoring and oversight, including approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the LTSS Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

DSHS and HHSC's LTSS will work together in a Quality Review Team, beginning in January 2009, to develop the quality assurance plan. The plan will: define data reporting to HHSC; create a baseline for QI activities; define the activities and the QI cycle. HHSC and DSHS will draft the QIS plan by June 1, 2009. HHSC and DSHS will initiate regular status and update meetings directed at evaluating the quality improvement system and identifying and prioritizing enhancements beginning December 1, 2009.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in

the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Texas will use existing service rate methodologies to set waiver service rates, when comparable services exist. When comparable services do not currently exist, reimbursement rates will be determined using a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements to set waiver rates.

The Texas Health and Human Services Commission (HHSC), the single state Medicaid agency, determines payment rates every two years. Payment rates are determined for each service and the rates for services are prospective and uniform statewide.

HHSC holds a public hearing on proposed reimbursement rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, materials pertinent to the proposed statewide uniform reimbursements are made available to the public.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider billings will flow directly from providers to DSHS and will not be routed through intermediaries. DSHS will review the billings in relation to waiver requirements and authorize payment through the state's accounting system. DSHS will submit data to HHSC for draw-down of the federal share.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ◉ **No. State or local government agencies do not certify expenditures for waiver services.**
- ○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The providers will submit an invoice, either through email or traditional mail, to DSHS staff responsible for the implementation and oversight of the waiver. DSHS staff will review to ensure all required information has been sent with the invoice and that the amount requested is within expected parameters. Any anomalies will require the DSHS staff to make additional inquires until the issue is resolved. (a) The DSHS review of the invoice will include verifying the waiver recipient's eligibility for the Youth Empowerment Services waiver services on the date of service delivery. Waiver services provided outside of waiver eligibility will not be reimbursed. (b) The DSHS review of the invoice will compare each invoice to each waiver recipient's approved plan of care and within the limits of the waiver. Services that are not on the plan of care and or exceed the limits approved by DSHS will not be reimbursed. (c) DSHS' annual review of the waiver provider agency will compare the billed services to the services documented in the waiver recipient's case record. DSHS will also conduct interviews with some of the service recipients to verify consumer satisfaction and verify the delivery of services.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  The State will begin processing waiver claims through the MMIS system by waiver renewal. Because of the system changes that must be implemented for this waiver, and the additional changes being made to the State's claims processing system for other programs, the State needs sufficient time to make system changes and test and implement these changes. The State is initially piloting the waiver in two counties and will evaluate the waiver during its first three years to determine whether it will be continued / expanded before investing the resources to modify the MMIS claims system. The State has performed preliminary analysis and will initiate development upon waiver approval. The State anticipates full implementation of the MMIS data and reporting functions by waiver renewal.

  The State plans to process waiver claims through MMIS in a manner similar to that used for other Texas 1915 (c) waivers. Texas will use its Clinical Management for Behavioral Health Services (CMBHS) system, an automated clinical record system for mental health and substance abuse services to collect and review information about waiver clients, including service plan, level of care, and eligibility information. YES waiver provider agencies will submit claims to CMBHS. CMBHS will check the claim information against the service authorization and eligibility information, and send all claims information to TMHP for loading into MMIS and for federal reporting purposes.
- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (•) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ○ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Payment of the cost of room and board is the responsibility of the individual except where room and board are provided under the waiver as part of out-of-home respite.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ○ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (○) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	4427.96	13894.00	18321.96	34207.00	11567.00	45774.00	27452.04
2	2587.43	15964.00	18551.43	35781.00	12095.00	47876.00	29324.57
3	2807.99	16677.00	19484.99	37426.00	12647.00	50073.00	30588.01

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Hospital
Year 1	300	300
Year 2	600	600
Year 3	600	600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The calculation of average length of stay for Year 1 of the waiver assumes that HHSC will phase-in waiver participants over the first

five months of the waiver at the rate of 60 participants per month at the start of each month to reach the enrollment limit of 300 participants. The average length of stay for Year 1 equals the total number of enrollment days for Year 1 of the waiver divided by the unduplicated number of participants.

HHSC assumes that the average participant will be enrolled in the waiver for 12 months before disenrolling. For Years 2 and 3 of the waiver, HHSC assumes that the number of waiver slots will remain fixed at 300 and that participants will enroll and disenroll in the waiver at the same rate as in Year 1 (i.e., 300 participants will enroll and 300 participants will disenroll in the waiver during the first five months of Years 2 and 3). Participants will continually flow into the waiver whenever an enrollment opportunity is available (i.e. there will be no vacancies in the waiver).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

HHSC developed expenditure and utilization estimates for the proxy population using data on similar services from other State departments (i.e., Department of State Health Services) or other states. HHSC also met with state staff and other stakeholders to assess the unmet needs of children with severe emotional disturbances. For each of the proposed services, HHSC reviewed other programs and existing requirements of similar populations as well as claims data analysis for similar services (when available) to estimate the intensity of services (utilization). In developing the expenditure estimates, HHSC established provider qualifications which were equivalent to the provider qualifications for other similar services or which met the special needs of these waiver participants. For each of the proposed waiver services, HHSC established either an hourly, monthly "per episode" or annual rate to fund the waiver service at the proposed scope and qualifications for the service. Expenditure estimates for Years 2 and 3 of the waiver for most services are inflated from Year 1 using the March 2008 Medical Consumer Price Index (4.6 percent) published by the U.S. Department of Labor, Bureau of Labor Statistics. An inflation factor was not applied to transitional services, minor home modifications, adaptive aids and supports or non-medical transportation.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For purposes of estimating the annual per capita Medicaid expenditures for all other services provided to individuals in the waiver program (i.e., Factor D'), HHSC obtained Medicaid expenditure data for any Medicaid enrolled child who had an inpatient psychiatric stay for the state fiscal year ending August 31, 2005 from the Texas Medicaid Healthcare Partnership (TMHP). These costs did not include dual eligible prescription drug costs. There was no dual eligible Part D prescription drug data in the claims data used to develop the cost-neutrality estimates. Accordingly, no adjustments were necessary to remove the costs of prescription drugs furnished to dual eligibles. Waiver participants who have Medicare Part D will obtain their medications through Medicare Part D, not the Medicaid waiver.

HHSC identified all Medicaid claims for each target population child with dates of service in FY 2005 and summarized the expenditures by non-inpatient (i.e. physician, dental, eye care, etc.) and other inpatient (i.e., inpatient expenditures which are not related to an inpatient psychiatric stay). In addition, HHSC made the following adjustments to factor D':

•Inpatient Psychiatric Care for Waiver Participants – HHSC assumes that some children enrolled in the waiver program will still require inpatient psychiatric care while enrolled in the waiver, so HHSC adjusted Factor D' to reflect expenditures for inpatient psychiatric care provided to waiver enrollees.

•Targeted Case Management for Waiver Participants – Individuals enrolled in the waiver program will receive targeted case management services through the State Plan. HHSC has made assumptions regarding the target population's utilization of these services.To account for waiver participant utilization of targeted case management services, HHSC removed targeted case management claims from the claims data, and added back in expenditures based on HHSC's utilization assumption.

After incorporating these adjustments, to calculate Factor D', HHSC totaled the non-waiver service expenditures and divided by the unduplicated number of Medicaid enrollees in the target population to estimate the average annual expenditures per person for SFY 2005. HHSC also applied the Medical Consumer Price Index from the Bureau of Labor Statistics to this estimate to adjust the expenditures forward to September 1, 2009 (the assumed start date of the waiver program).

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For purposes of estimating the annual average per capita Medicaid expenditures for inpatient psychiatric hospital care that would be incurred for individuals served in the waiver, were the waiver not granted (i.e., Factor G), HHSC obtained institutional Medicaid expenditure data for any Medicaid enrolled child who had an inpatient psychiatric stay for the state fiscal year ending August 31, 2005 from the TMHP.
Using this data, HHSC estimated Factor G for the target population by identifying all Medicaid inpatient psychiatric expenditures in SFY 2005 for each target population child. HHSC identified inpatient psychiatric stays as those inpatient stays where the primary diagnosis for the patient was '290' to '31499.'
To calculate Factor G, HHSC totaled these expenditures and then divided them by the unduplicated number of Medicaid enrollees in the target population to estimate the average annual inpatient psychiatric expenditures per person for SFY 2005. HHSC applied the Medical Consumer Price Index from the Bureau of Labor Statistics to this estimate to adjust the expenditures forward to September 1, 2009 (the assumed start date of the waiver program).

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

G'is adjusted based on historical utilization of all Medicaid services other than inpatient psychiatric institutional services by children with three or more inpatient psychiatric stays in State Fiscal Year 2005. It includes expenditures for other Medicaid services those children received while in inpatient psychiatric hospitals and other Medicaid services received when those children were not in inpatient psychiatric hospitals. Without the waiver, HHSC assumes that the children would experience multiple inpatient stays during the year, but would likely not be in a psychiatric institution for the entire year. G' does not include inpatient psychiatric costs since these costs are already included in factor G. Accordingly, the YES waiver Factor G' estimate includes all Medicaid services, other than institutional services, for Medicaid children with three or more acute inpatient psychiatric stays in State Fiscal Year 2005.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Respite
Paraprofessional Services
Non-Medical Transportation
Transitional Services
Supportive Family-based Alternatives
Minor Home Modifications
Community Living Supports (CLS)
Family Supports
Adaptive Aids and Supports
Specialized Psychiatric Observation
Professional Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

					Component	Total

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Cost	Cost
Respite Total:						**106335.00**
Respite	Day	150	8.34	85.00	**106335.00**	
Paraprofessional Services Total:						**146696.55**
Paraprofessional Services	Hour	300	10.01	48.85	**146696.55**	
Non-Medical Transportation Total:						**25825.80**
Non-Medical Transportation	Trip	75	20.02	17.20	**25825.80**	
Transitional Services Total:						**85075.00**
Transitional Services	Episode	41	0.83	2500.00	**85075.00**	
Supportive Family-based Alternatives Total:						**389340.72**
Supportive Family-based Alternatives	Day	18	75.06	288.17	**389340.72**	
Minor Home Modifications Total:						**31125.00**
Minor Home Modifications	Per item	150	0.83	250.00	**31125.00**	
Community Living Supports (CLS) Total:						**203199.12**
Community Living Supports (CLS)	Hour	63	21.27	151.64	**203199.12**	
Family Supports Total:						**146696.55**
Family Supports	Hour	300	10.01	48.85	**146696.55**	
Adaptive Aids and Supports Total:						**74700.00**
Adaptive Aids and Supports	Per Item	300	0.83	300.00	**74700.00**	
Specialized Psychiatric Observation Total:						**25223.70**
Specialized Psychiatric Observation	Episode	30	0.83	1013.00	**25223.70**	
Professional Services Total:						**94170.00**
Wrap-around - Professional	Hour	300	5.00	62.78	**94170.00**	
			GRAND TOTAL:			**1328387.44**
			Total Estimated Unduplicated Participants:			**300**
			Factor D (Divide total by number of participants):			**4427.96**
			Average Length of Stay on the Waiver:			304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**133365.00**
Respite	Day	300	5.00	88.91	**133365.00**	
Paraprofessional Services Total:						**183960.00**
Paraprofessional Services	Hour	600	6.00	51.10	**183960.00**	
Non-Medical Transportation Total:						**30960.00**
Non-Medical Transportation	Trip	150	12.00	17.20	**30960.00**	
Transitional Services Total:						**101250.00**
Transitional Services	Episode	81	0.50	2500.00	**101250.00**	
Supportive Family-based Alternatives Total:						**386645.40**
Supportive Family-based Alternatives	Day	36	45.00	238.67	**386645.40**	
Minor Home Modifications Total:						**37500.00**
Minor Home Modifications	Per item	300	0.50	250.00	**37500.00**	
Community Living Supports (CLS) Total:						**254823.03**
Community Living Supports (CLS)	Hour	126	12.75	158.62	**254823.03**	
Family Supports Total:						**183960.00**
Family Supports	Hour	600	6.00	51.10	**183960.00**	
Adaptive Aids and Supports Total:						**90000.00**
Adaptive Aids and Supports	Per Item	600	0.50	300.00	**90000.00**	
Specialized Psychiatric Observation Total:						**31788.00**
Specialized Psychiatric Observation	Episode	60	0.50	1059.60	**31788.00**	
Professional Services Total:						**118206.00**
Wrap-around - Professional	Hour	600	3.00	65.67	**118206.00**	
				GRAND TOTAL:		**1552457.43**
				Total Estimated Unduplicated Participants:		**600**
				Factor D (Divide total by number of participants):		**2587.43**
				Average Length of Stay on the Waiver:		183

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D

fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**139500.00**
Respite	Day	300	5.00	93.00	**139500.00**	
Paraprofessional Services Total:						**192420.00**
Paraprofessional Services	Hour	600	6.00	53.45	**192420.00**	
Non-Medical Transportation Total:						**30960.00**
Non-Medical Transportation	Trip	150	12.00	17.20	**30960.00**	
Transitional Services Total:						**101250.00**
Transitional Services	Episode	81	0.50	2500.00	**101250.00**	
Supportive Family-based Alternatives Total:						**477316.80**
Supportive Family-based Alternatives	Day	36	45.00	294.64	**477316.80**	
Minor Home Modifications Total:						**37500.00**
Minor Home Modifications	Per item	300	0.50	250.00	**37500.00**	
Community Living Supports (CLS) Total:						**266534.42**
Community Living Supports (CLS)	Hour	126	12.75	165.91	**266534.42**	
Family Supports Total:						**192420.00**
Family Supports	Hour	600	6.00	53.45	**192420.00**	
Adaptive Aids and Supports Total:						**90000.00**
Adaptive Aids and Supports	Per Item	600	0.50	300.00	**90000.00**	
Specialized Psychiatric Observation Total:						**33250.20**
Specialized Psychiatric Observation	Episode	60	0.50	1108.34	**33250.20**	
Professional Services Total:						**123642.00**
Wrap-around - Professional	Hour	600	3.00	68.69	**123642.00**	

GRAND TOTAL:	**1684793.42**
Total Estimated Unduplicated Participants:	**600**
Factor D (Divide total by number of participants):	**2807.99**
Average Length of Stay on the Waiver:	183